Medicare, Medigap, and *you*

A Guide to Making *Your* Best Choices About:

- Medicare
- Medicare Supplements (Medigap)

PART OF THE CONSUMER GUIDE SERIES

PUBLISHED BY STATEWIDE HEALTH INSURANCE BENEFITS ADVISORS (SHIBA), **A FREE PUBLIC SERVICE SPONSORED BY THE OFFICE OF INSURANCE COMMISSIONER DEBORAH SENN**

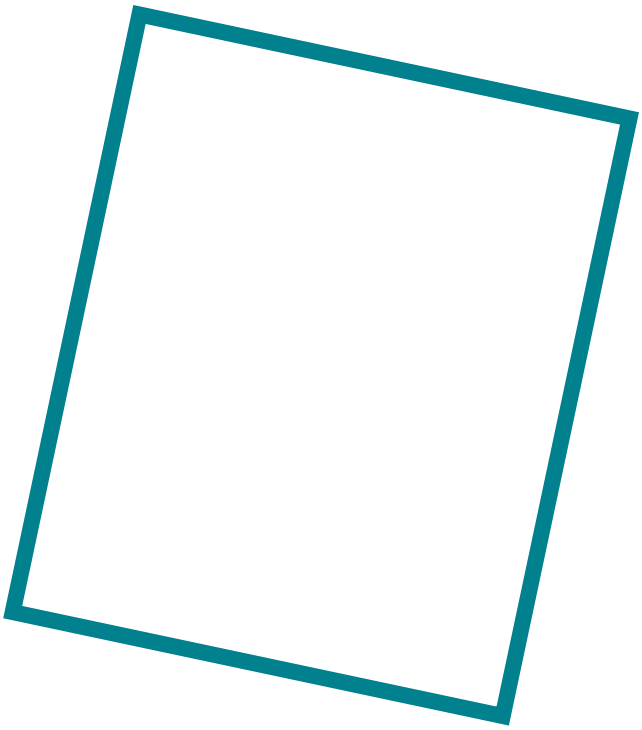
A message from Insurance Commissioner Deborah Senn

Dear Consumer:

My office is committed to ensuring that consumers in Washington State are fully informed about health insurance. This is one of a series of other guides and brochures we publish that may help you with health insurance questions and issues. I encourage you to call or write for the other booklets if you need them—just use the order form at the back of this guide.

Another important part of our consumer assistance effort is the Statewide Health Insurance Benefits Advisors program, which we call SHIBA. SHIBA is a special educational service—a statewide network of trained volunteers who educate, assist, and advocate for consumers regarding health insurance and related issues, including long-term care, Medicare supplements, managed care, and employer/retirement benefits.

Volunteers across the state are trained by my staff to help you gather information, compare options and assess your needs. SHIBA volunteers have no affiliation with any insurance company or product. All of their advice is *free*.



If you have questions about health insurance, I urge you to contact a SHIBA volunteer and take advantage of their objective, confidential assistance and expertise. It's easy. Just pick up the phone and dial toll-free: 1-800-397-4422 for the number of the SHIBA office nearest to your home.

DEBORAH SENN
STATE INSURANCE COMMISSIONER

WITH QUESTIONS, COMMENTS, COMPLAINTS ABOUT OTHER INSURANCE (AUTO, LIFE , HOMEOWNERS, DISABILITY, ETC.) CALL:

INSURANCE COMMISSIONER'S TOLL-FREE CONSUMER HOT LINE
1 (800) 562-6900

Medicare Overview

Medicare alone isn't enough for most beneficiaries

When it was enacted in 1965 as part of the Social Security Act, Medicare's purpose was to increase access to health care and reduce its financial burden on older, retired or disabled Americans. Medicare was never intended to pay 100 percent of all medical bills, but to offset the most pressing medical expenses by providing a basic foundation of benefits.

Thus, while it provides considerable support, *Medicare does not cover all services that you might need.* Even those that are covered are not covered in full. There are deductibles, coinsurance, and—with some physicians—charges over and above what Medicare considers reasonable and necessary (the allowed charge). Medicare will not pay above that limit.

That's why you may need additional coverage—to fill the gaps Medicare was never intended to fill. Most seniors need some kind of plan, policy or program to fill in these gaps in Medicare's basic coverage. These products might be considered "Medicare enhancements."

There are several ways to enhance Medicare:

- ☑ with a special private insurance policy called a Medigap policy (Medicare supplement),
- ☑ with employment-related benefits,
- ☑ with a managed care plan.

This guide is designed to help you understand the basics of how Medicare works, and to evaluate one system of Medicare enhancement: the fee-for-service (reimbursement) system using a Medigap policy to fill the gaps.

SHIBA publishes other guides designed to explain other Medicare enhancement options—*Retirement and Your Health Insurance* and *Managed Care, Medicare and You*. To order these guides, use the order form on the last page of this guide, or call SHIBA at 1 (800) 397-4422.

Medicare Part A coverage

Part A provides substantial hospital care benefits, covering reasonable and necessary services and supplies to treat illness or injury. It also provides *very limited* coverage for skilled nursing care, rehabilitative services, and home health care after hospitalization; and hospice care for the terminally ill. It does *not* pay for personal (custodial) care (e.g., help with eating, dressing, walking or other Activities of Daily Living).

Under Medicare Part A, a period of hospitalization is called a benefit period. A benefit period begins the day you are admitted into a hospital. It ends when you have been out of the hospital or a skilled nursing facility for 60 consecutive days (or when you have not received Medicare-approved

skilled care for 60 days). If you are re-admitted within that 60 days, you are still in the same benefit period and would not pay another deductible. If you are admitted to a hospital after that benefit period ends, an entirely new benefit period begins (and a new deductible is owed).

Medicare Part B coverage

Part B helps pay for medical and surgical care, diagnostic tests and procedures, some hospital outpatient services, laboratory services, durable medical equipment and a variety of medical services and supplies.

It does *not* cover prescription drugs, nor most preventive or routine services, including dental care, acupuncture, foot care, eye examinations, eyeglasses, hearing aids, physicals or other services not related to treatment of illness or injury. Two notable exceptions are routine Pap smears and mammography, which are covered.

"Fee for service"

How your health and medical services are delivered and paid for, what your out-of-pocket costs may be, and how those costs are covered depends on the type of Medicare enhancement solution.

You may obtain Medicare-covered services using the fee-for-service approach (paying "as you go" for each service/provider) and being reimbursed by private insurance to fill gaps. (We will briefly discuss other options later in this guide: obtaining Medicare-covered services from a managed care plan or from a former employer's plan. Consult SHIBA's *Managed Care, Medicare and You; Managing Your Managed Care;* and *Retirement and Your Health Insurance* for additional, detailed information on these options.)

The "fee-for-service" system is a pay-per-visit arrangement. You see a licensed physician at a facility certified by Medicare when you need a treatment, service or exam. You are billed each time you receive care. Depending on the service, Medicare will either cover part of the bill or none. Under fee-for-service, you are responsible for:

- Medicare deductibles and coinsurance;
- fees for services not covered by Medicare;
- amounts charged by providers that exceed Medicare's approved charge for that service.

Under the fee-for-service system, you need insurance to pay out-of-pocket expenses not covered by Medicare when you need medical or hospital care. The goal of insurance is to cover some or all of these expenses (as well as deductibles and co-payments).

Out-of-pocket expenses

Out-of-pocket expenses occur:

- when you receive a service not covered by Medicare;
- when you receive a service only partially covered by Medicare;
- when you choose a provider whose fees exceed Medicare's approved charges.

How much of these expenses you pay out of pocket depends on the extent of your insurance coverage. In the next section of this guide, we will discuss situations in which out-of-pocket expenses can occur even when covered by Medicare, and how Medigap policies—as one type of Medicare enhancement solution—can address this.

PART A Medicare benefits are as shown below:

SERVICE	MEDICARE PAYS	YOU PAY
In-patient hospital, days I through 60	After DEDUCTIBLE, 100% of approved charges	DEDUCTIBLE
In-patient hospital, days 61 through 90	Approved charges over & above DAILY CO-PAYMENT	DAILY "Days 61-90" CO-PAYMENT
In-patient hospital, days 91 through 150*	Approved charges over & above DAILY CO-PAYMENT*	DAILY "Days 91-150" CO-PAYMENT*
THESE LIFETIME RESERVE DAYS MAY ONLY BE USED ONCE IN A LIFETIME (THOUGH THEY MAY BE USED OVER MULTIPLE BENEFIT PERIODS).		
Skilled nursing facility, days 1 through 20 (IF YOU ENTER WITHIN 30 DAYS OF A 3-DAY HOSPITAL STAY—SEE PP. 15-16)	100% of approved charges (IF YOU ENTER WITHIN 30 DAYS OF 3-DAY HOSPITAL STAY—SEE PP. 15-16)	NOTHING—*IF...* YOU ENTER WITHIN 30 DAYS OF A 3-DAY HOSPITAL STAY AND MEET OTHER CONDITIONS (SEE PP. 15-16)
Skilled nursing facility, days 21 through 100	Approved charges after DAILY SNF CO-PAYMENT	DAILY SNF Days 21-100 CO-PAYMENT

The deductibles and co-payments for which you are responsible (as shown in these charts) change annually. To obtain current figures, consult HCFA's *Medicare Handbook* or a local SHIBA volunteer.

PART B Medicare benefits are as shown below:

SERVICE	MEDICARE PAYS	YOU PAY
Doctors, outpatient hospital care, durable medical equipment, and other services and supplies	80% of approved charges after ANNUAL DEDUCTIBLE OF $100	• First $100 each year (ANNUAL DEDUCTIBLE) of approved charges • 20% of approved charges • 100% of excess charges (charges over and above Medicare-approved amount) • 100% for services not covered by Medicare
Diagnostic testing, lab services	100% of approved charges	Nothing

Medigap Insurance

Before you decide on any Medicare-enhancing solution, familiarize yourself with the detailed benefits, rules and procedures of Medicare itself.

The Health Care Financing Administration (HCFA), which administers the Medicare program, produces these guides:

- *The Medicare Handbook;*
- *Guide to Health Insurance For People With Medicare;*
- *Medicare and Other Health Benefits.*

All of these are free, and can be obtained by writing to the address given at the end of this guide (see *"Resources"* on page X).

What are Medigap policies?

Medicare supplements (commonly called Medigap policies) are health insurance policies that provide a way to fill the coverage gaps left by Medicare, which are illustrated by the charts on the previous page. Depending on which one you buy, the policy will cover some or all of the potential charges you see in the "You Pay" columns of those charts.

Are all Medigap policies the same?

In 1992, federal regulations set uniform standards for Medicare supplement policies. Now there are 10 standard Medicare supplements (Plan A through Plan J).

So, while Plans A through J differ *from one another,* each Plan conforms to federal standards for that particular Plan. In other words, all Plan Bs meet specific standards; all Plan Gs conform to a set of standards, and so on.

For example, no matter which company you buy Plan E from, it will cover all of the same things that any other company's Plan E does. No company offers a "better" or different plan E. Therefore, insurance companies compete with these plans based on premiums, service, company reliability, and issues such as waiting periods or guaranteed issue after open enrollment.

Prior to 1992, there was no standardization among these plans.

Plan A is the most basic policy and offers core benefits. These include the daily coinsurance you would normally pay for days 61-90 in hospital, the daily co-pay you would pay during lifetime reserve days 91-150, and the 20 percent that you would pay for doctors and other services if you relied solely on Medicare.

The core benefits also cover 100% of hospital costs for a maximum of 365 days, once in a lifetime, *after* your Medicare benefits are exhausted.

Each of the nine plans named B - J includes all of the core benefits offered in Plan A, as described above, *plus* varying levels of additional coverage. Each plan addresses a different set of Medicare "gaps," adding benefits such as coverage for medical emergencies in a foreign country, prescription drugs, or preventive medical care. You can choose the best policy for you based on your health, lifestyle and other factors.

NOTE: Policies purchased prior to 1992 were not changed by the regulations that became effective that year, and thus do not conform to the current uniform standards.

Will a Medigap policy cover everything Medicare doesn't?

As you will see in the chart on the next page, no single A through J policy covers everything—but then most people don't need every single benefit. Each plan covers a different grouping of "gaps." The idea is to carefully consider your particular needs and choose the supplement policy that fills the gaps most likely to affect *you*.

A detailed explanation of each plan is featured in the free government publication *Guide to Health Insurance for People with Medicare* (see "Resources" in back).

What is "open enrollment?"

By law, people age 65 or above have the right to enroll in any Medigap health insurance plan within six months after their Medicare Part B coverage begins. *No one* age 65 or older may be denied coverage because of a pre-existing medical condition if they apply for a Medigap policy during this six months.

When does coverage begin?

This varies by policy, but Washington state legislation limits Medigap policy waiting periods to a 90-day maximum in *all policies purchased after January 1, 1996.*

In a waiting period, medical conditions for which you have been treated previously can be excluded from your coverage until the waiting period has elapsed. Check with your agent, or consult a SHIBA volunteer, for assistance in determining what is and is not covered during your policy's waiting period.

In January 1995, Medigap policies E & J became available to Washington state resident Medicare enrollees through the Washington State Health Care Authority (HCA). The plans are issued only when certain criteria are met, such as new residency; retirement; first-time Medicare enrollment; or other special periods which may be designated in the future. There are no pre-existing condition waiting periods for these plans.

10 STANDARD MEDICARE SUPPLEMENT PLANS

CORE BENEFITS	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E	PLAN F	PLAN G	PLAN H	PLAN I	PLAN J
Part A Hospital (Days 61-90); Lifetime Reserve Days (Days 91-150); 365 Lifetime Hosp. Days at 100%; Parts A & B Blood Deductible; Part B 20% Coinsurance	X	X	X	X	X	X	X	X	X	X
ADDITIONAL BENEFITS	A	B	C	D	E	F	G	H	I	J
Skilled Nursing Coinsur.			X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X
Part B Excess Charges						100%	80%		100%	100%
Foreign Travel			X	X	X	X	X	X	X	X
At-Home Recovery				X			X		X	X
Prescription Drugs								X	X	X
Preventive Medical Care					X					X

(NOTE: Policies purchased prior to 1992 were not changed by the federal regulations enacted that year, and thus do not conform to current uniform standards.)

What is "Accepting Assignment?"

For many services and procedures, there is a limit to the fee amount Medicare will approve. This is called the "approved charge" (or allowable, eligible or accepted charge).

In the fee-for-service system, when doctors or other health care providers accept assignment, they agree to accept this approved amount—the maximum charge Medicare will allow for that service—as payment in full. In other words, they won't bill you more for a service than Medicare will approve. They may be referred to as participating physicians.

Some physicians accept assignment as a general practice; others may do so on a case-by-case basis. Ask before you visit a new physician.

If a provider does accept assignment, this minimizes—but does not eliminate—your share of the bill. Medicare pays 80 percent of the approved charge. You are still responsible for the coinsurance—20 percent of the approved charge.

If you have a Medigap policy, it will cover your portion of the approved charge. (All Plans A through J cover the 20 percent coinsurance—it's a core benefit.)

What if a provider does not "accept assignment?"

A provider who does not accept assignment can charge more than Medicare approves. In this case, you are responsible not only for the usual 20 percent of the approved charge for that service, but also for *100%* of the excess—the portion of the fee that exceeds the approved amount.

Medicare-approved charge for Service XYZ:	$100.
Doctor does not accept assignment, charges:	$115.
You pay:	
• 20% of approved charge (20% of $100):	$20.
• Charges in excess of the approved charge for this service ($115 minus $100):	$15.
TOTAL YOU PAY:	$35.
Medicare pays 80% of the approved portion (80% of 100):	$80.

However, there is usually a limit to *how much* more than the approved amount a provider may charge. This is called a limiting charge. Non-participating physicians may not charge more than 115% of the Medicare-approved amount for a covered service *(except in outpatient hospital clinics).*

Also, several Medigap policies cover excess charges (see chart on page 7). If you have one of these, it will pay all or part of the amount over and above what Medicare approves *(except in outpatient hospital clinics).*

More details about these issues can be found in the government's free *Medicare Handbook* and *Guide to Health Insurance for People with Medicare* (see "Resources," inside back cover).

You can also obtain a free listing of participating doctors and suppliers in your area by calling your local Medicare carrier (see "Resources," inside back cover).

What if I can't afford a Medigap policy?

If an individual's income and assets are below a certain amount, they can qualify for Medicaid to pay nearly all of their health care costs. The qualifying income/asset limits change annually.

Even if you do not qualify for full Medicaid benefits, there are partial subsidies for which you may be eligible: the Qualified Medicare Beneficiary (QMB) Program or the Specified Low Income Medicare Beneficiary (SLMB) Program. In these cases, the state Medicaid program helps pay Medicare expenses for qualifying seniors. QMB pays all Medicare premiums, deductibles and co-payments. SLMB pays Medicare Part B premiums.

To qualify for QMB or SLMB, your income cannot exceed a specific monthly amount and your assets must also be below a certain amount. A home and car are usually exempt. Again, these qualifying figures change annually. For current figures and to determine if you qualify, contact the Department of Social and Health Services (DSHS) at (800) 562-3022, or the Senior Information and Assistance National Elder Care Locator service at (800) 677-1116.

If you find that your income is too high to qualify for any of these programs, yet you cannot afford a Medigap policy, contact your county's Area Agency on Aging. There may be other programs or resources available.

Do I need more than one Medigap policy?

One Medigap policy is sufficient in most cases. The 10 standard policies each offer different groupings of benefits to address a wide range of individual needs.

It is illegal for an agent or company to sell you a plan that duplicates coverage you already have (unless you agree to cancel the coverage you already have).

Can my insurer cancel my Medigap policy?

Medigap policies purchased by individuals are guaranteed renewable. As long as you pay your premiums on time, your policy cannot be terminated without your permission.

However, group policies may be cancelled and converted to similar—though not the same—coverage. Group policies are those that are issued to you through a legitimate group, such as an employer organization, and require employment or membership in the organization. Certificates of insurance are issued to participating members. To determine if you have a group policy, contact a SHIBA volunteer.

What if I change my mind after purchasing a policy?

Washington state law gives you a 30-day "free-look" period after you receive a Medigap policy. If you change your mind for any reason, return it *within that time* for a full refund.

Are there other ways to fill gaps or extend benefits?

Yes. You can sometimes keep your employer's plan, and its benefits may supplement Medicare. Another option is to enroll in a Medicare-contracting managed care plan, in which you pay a small monthly premium (or no premium, in some cases) for a package of services through a managed care provider. Depending on your needs, this may be an effective option.

Thoroughly inform yourself about the pros and cons of managed care before you enroll. Order SHIBA's *Managed Care, Medicare and You* and *Managing Your Managed Care* (see order form at back of guide), or consult a SHIBA advisor for more information and a side-by-side comparison of coverage.

What if I'm covered by an employer's health plan?

Some Medicare beneficiaries are covered by an employer's plan, either because they continue to work after age 65 or because the employer plan covers retirees. In some cases this coverage is superior to a Medigap policy or managed care plan. A SHIBA volunteer can help you compare your employer plan to other options, so you can decide which best meets your need. Ask for an "Employment-Related Benefits" specialist.

To avoid possible penalties, it is important to fully understand the many complex enrollment deadlines and rules associated with Medicare around retirement. For complete information about your choices as a retiree or pre-retiree, order SHIBA's free *Retirement and Your Health Insurance* (order form at back of guide).

Policy Definitions

Following are standardized definitions of terms or benefits specifically found in Medigap policies.

At-home recovery: This benefit extends the Medicare benefit to provide coverage for short-term, at-home assistance with activities of daily living for those recovering from illness, injury or surgery. It pays up to $40 a day or $1,600 annually, *but only after at least one visit is paid by Medicare. To qualify, you must first be eligible for Medicare home care.*

Excess charges: The difference between the actual Medicare Part B charge *as billed* and the *Medicare-approved Part B charge*. This is not to exceed any charge limitations established by the Medicare program or state law, such as the physicians' limiting charge, or "usual and customary" charge.

Foreign travel: This benefit covers medically necessary *emergency* care received in a foreign country at *80 percent of the billed charge* for Medicare-eligible emergency hospital, doctor and medical care costs. This care must be of the kind that would have been covered in the U.S. by Medicare and must begin *during the first 60 days* of each trip outside the U.S. This is subject to $250 deductible and a lifetime maximum of $50,000.

Basic drug benefit: Coverage for *50 percent* of outpatient prescription drug charges after a *$250 calendar year deductible*, to a *maximum of $1,250 annual benefits,* to the extent not covered by Medicare.

Extended drug benefit: Coverage for *50 percent* of outpatient prescription drug charges after a *$250 calendar year deductible*, to a *maximum of $3,000 annual benefits,* to the extent not covered by Medicare.

Preventive care benefit: This coverage pays *100 percent of the Medicare approved charges up to $120 annually* for an annual preventive physical exam, such as a mammogram, digital rectal exam, thyroid function test, diabetes screening, flu shot, or any other preventive measures deemed appropriate by the physician.

Glossary

Acute: A condition that begins suddenly and doesn't last very long. This is the opposite of chronic. A broken hip is an acute condition.

Accept assignment: When doctors and other health care providers accept assignment, they agree to bill no more than the approved charge for a service. In other words, they won't charge more than Medicare will approve.

Approved charge: Also called the allowable, eligible, or accepted charge, this is the preset maximum that Medicare will approve for a particular service or procedure (of which Medicare will reimburse 80%).

Benefit period: A designated period of time during and after a hospitalization for which Medicare Part A will pay benefits.

Chronic: A medical condition that is recurring or lasts a long time—e.g., arthritis.

Coinsurance: The balance of a covered health expense that an individual is required to pay after insurance has covered the rest. This may also be called your co-payment.

Deductible: A pre-determined amount of money, designated in the insurance policy, that an individual making a claim must pay before the policy begins to pay.

Guaranteed renewable: A policy that cannot be canceled without the policyholder's consent (except for nonpayment of premiums).

Limiting charge: The maximum a physician who does not accept assignment may legally charge for a Medicare-covered service/procedure.

Managed care: A health coverage plan in which you pay a monthly premium (or no premium) for a complete package of services through a network of providers you must use.

Medicaid: A financial assistance program administered by state government with federal assistance that helps cover medical care for impoverished individuals and families.

Enrollment period: If you are 65 or over, you have the right to enroll in any Medigap insurance plan within six months of when your Medicare Part B coverage begins, and cannot be denied based on any pre-existing condition (though a waiting period might be imposed).

Pre-existing condition: A medical condition or problem diagnosed or treated prior to the purchase of an insurance policy. Medigap policies may incur up to a 90-day waiting period before coverage for that condition begins.

Skilled care: When conditions require the care of skilled medical staff (such as registered nurses or physical therapists) it is called skilled care. In most cases, it must be ordered by a physician before insurance will cover it.

Usual and customary charge: The fee most commonly charged by providers for a particular service, procedure or treatment, for that specialty, in that geographic area.

Helpful Hints
on buying health insurance

• Read your policy and be sure you understand what it does and does not cover. If there is anything you do not understand, do not sign anything or pay for anything before someone (a knowledgeable friend or family member, SHIBA volunteer, or attorney) is able to answer your questions.

• Ask for a plain-language outline of coverage. This is an easy-to-understand summary of a policy's benefits, exclusions and limitations. Insurers are required to provide them for every policy. You should take advantage of it if the policy's "legalese" has you confused.

• Don't be pressured into "buying now." You will save a great deal more in the long run if you take the time to understand your rights and options, and choose the best policy for you, than if you rush to take advantage of a "special offer" the agent claims is about to expire.

Ask for a copy of the policy and review it with a knowledgeable friend or family member, SHIBA volunteer, or attorney before you buy.

• Always pay for your policy by check or money order—not with cash. Or arrange for monthly automatic withdrawal.

• Make the check payable to the insurance company, not the agent or agency.

• Get a receipt any time you give a check to an agent or broker.

• Double-check to make sure all the information on your application form is correct. If an insurance company has issued you a policy based on incorrect information, it may consider this grounds for canceling your policy or not paying certain claims.

• Choose an agent with whom you feel comfortable, who is experienced in the type of insurance you are purchasing, who is willing to answer your questions or obtain information for you, and who is knowledgeable and helpful. You are not required to deal with any particular agent; if you are unhappy with one agent, find another.

IF YOU NEED MORE HELP...

SHIBA is an impartial, confidential resource to help you evaluate, choose and use your health insurance. A statewide network of trained volunteers stands ready to educate you on health insurance issues, so you can make informed decisions.

Our highly trained volunteer counselors have up-to-date information on most health insurance concerns. They can answer questions and assist with insurance planning.

Their services are FREE. And they have no affiliation with any insurance company or product.

SHIBA was the first senior health insurance peer counseling program in the nation, and is now a model for the rest of the United States.

There's a SHIBA unit in nearly every county in Washington State. Call today to get the number of the SHIBA sponsor nearest you.

1-800-39-SHIBA
(1-800-397-4422)

RESOURCES

HOTLINES, ORGANIZATIONS

- For consumer brochures about health insurance, and referral to nearest local SHIBA office: SHIBA Hotline / (800) 397-4422

- With all other insurance questions/comments/suggestions *(auto, life, homeowner, etc.)* : Insurance Commissioner Deborah Senn's Consumer Hotline / (800) 562-6900

- Health Care Financing Administration (HCFA)

Consumer Services (206) 615-2354 Medicare Hotline (800) 638-6833
Medicare Managed Care (206) 615-2351

- Medicare Part A & B Intermediaries & Carriers

Blue Cross Part A Fiscal Intermediary (206) 670-1010
Mutual of Omaha Part A Fiscal Intermediary (402) 351-2860
Blue Cross Blue Shield of North Dakota - Part B Carrier (800) 444-4606
Peer Review Organization (PRO) (206) 368-8272, (800) 445-6941

- Social Security Administration (800) 772-1213

- Senior Information and Assistance

National Elder Care Locator Service (800) 677-1116

PUBLICATIONS

TO ORDER CONSUMER PUBLICATIONS FROM THE OFFICE OF INSURANCE COMMISSIONER, USE ORDER FORM ON OPPOSITE PAGE.

- *The Medicare Handbook*
  Health Care Financing Administration (HCFA) (800) 638-6833
  6325 Security Boulevard, Baltimore, MD 21207

- *Guide to Health Ins. for People w/Medicare*
- *Medicare and Other Health Benefits*
- *Medicare and Coordinated Care Plans*
- *Medicare: Hospice Benefits*
  Consumer Information Center, Pueblo, CO 81009

- *A Shopper's Guide To Long-Term Care Insurance*
  National Association of Insurance Commissioners (NAIC)
  Publications Dept., 120 West 12th Street, Suite 1100
  Kansas City, MO 64105

- *Medicare Managed Care Plans Comparison Chart*
  on the Office of the Insurance Commissioner website at:
  http://www.wa.gov/ins/

PUBLICATIONS ORDER FORM

PLEASE PRINT NAME, ADDRESS AND TELEPHONE NUMBER.

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Street Address _____

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Daytime phone number *(in case we have a question about your order)* _____

PLEASE SEND ME ONE EACH OF THE FOLLOWING PUBLICATIONS:

(please check only those you wish to receive)

- ☐ SHIBA General Info Brochure (Trifold)
- ☐ Medicare, Medigap and You
- ☐ Managed Care, Medicare and You
- ☐ Managing Your Managed Care
- ☐ Retirement and Your Health Insurance
- ☐ Health Insurance Fraud Costs You
- ☐ Did You Forget Something? A Look at Planning for Long-Term Care
- ☐ The Consumer's Guide to Long-Term Care Planning (scheduled publication 7/97)

- ☐ Please send information on becoming a SHIBA volunteer.
- ☐ I'm interested in having a speaker for my group. Please call me.

Name of group _____

Size of group (audience) _____

Phone number _____

SEND THIS FORM TO:

Office of the Insurance Commissioner
Deborah Senn, Insurance Commissioner
SHIBA - Publications
P.O. Box 40256
Olympia, WA 98504-0256

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SHIBA (Statewide Health Insurance Benefits Advisors)
Office of the Insurance Commissioner
P.O. Box 40256
Olympia, WA 98504-0256

SHIBA
1-800-397-4422

Medicare, Medigap & You

is part of the consumer information series
published by The Office of the Insurance Commissioner

SEE ALSO:

- Managed Care, Medicare & You
- Managing Your Managed Care
- Retirement and Your Health Insurance
- Did You Forget Something? (Long-Term Care Partnership)
- Consumer's Guide to Long-Term Care Planning
- Health Insurance Fraud Costs *You*

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